



Medicaid Mobility for Residents

Disclaimer

The following presentation is accurate as of the date reflected on the slides in accordance with Medicaid policy. To obtain updates and more detailed policy information please review the Michigan Medicaid Provider Manual and Policy bulletins.



Agenda

- Nursing Facility Per Diem
- Locate Medicaid Information
- Evaluation
- MSA-1656, Addendum A & Documentation
- MSA-1656 vs. MDS
- Addendum A
- Questions?



What's in the Per Diem?

Examples of items included in the nursing facility daily rate:

Standard manual wheelchairs

Hospital beds

Walkers

Bandages

Diabetic test strips and lancets

What is not included in the Per Diem?


- Power Wheelchairs
- Power Operated vehicles (POV's)
- Custom wheelchair seating
- Manual wheelchairs with custom wheelchair seating




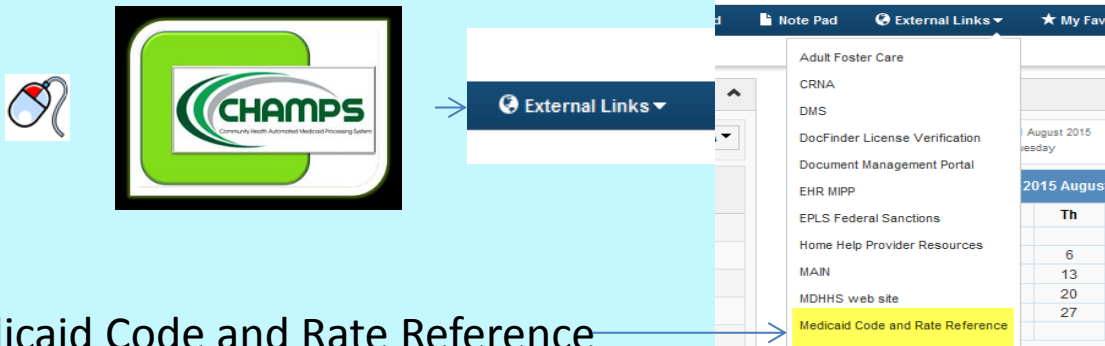
Locate Medicaid Information

www.michigan.gov/medicaidproviders

Select Policy and Forms:

 on Medicaid Provider Manual for Nursing Facility Chapter and/or Medical Supplier Chapter.

 Forms to locate MSA-1656 and/or Addendums



Medicaid Policy & Forms webpage. If there are discrepancies in determinations, they will be resolved in the favor of the Provider.

Code Details				
Code : K0001				
Category : HCPCS/CPT Codes				
Gender : Both				
Long Description : STANDARD WHEELCHAIR				

Indicators				
Claim Type	Indicator Name	Indicator Value	Age Range	Include/Exclude
	Prior Authorization	1-PA All Ages		Include
	Supplies / DME-per diem	Y-Included In Per-Diem		Include
	Medicaid Covered	Y-Yes		Include
	Hospital Discharge - Bypass PA	Y-Yes		Include

Medicaid Code and Rate Reference

Supplies/DME-per diem

Y= included in NF daily rate

Evaluation



Care Conference

Doctor sees patient, writes order

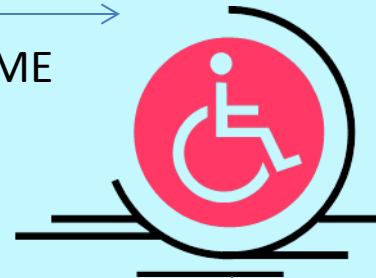


PT &/or OT Evaluates

PT/OT & resident
work with DME & trial
Equipment to find the
appropriate wheelchair



Send to DME



PT/OT completes MSA-1656
&/addendum A gathers MDS, Plan of
Care, nursing notes, Dr. order

DME submits PA, MSA-1656
& documentation to MDHHS

Prior authorization

MSA-1656, Addendum A & Documents

DRAFT
MINIMUM DATA SET, Version 3.0 (MDS 3.0)

FOR NURSING HOME RESIDENT
ASSESSMENT AND CARE SCREENING



Nursing Notes	
Date & Time	Documentation
8-18-15 8:00AM	"They're Gr-r-reat!" T.T.T.



Plan of Care:

dkddkdkdkdkd

MSA-1656

Addendum A

What is the MSA-1656?

- Evaluation and Medical Justification for Complex Seating and Mobility Devices
- Basic medical/functional mobility goals
- A baseline for Mobility Related Activities of Daily Living (MRADL's)

Who completes it?

- Physiatrist and/or:
- Physical Therapist (PT) and/or Occupational Therapist (OT) and/or
- Rehabilitation Registered Nurse (RN) w/ at least 2 years of rehab seating experience

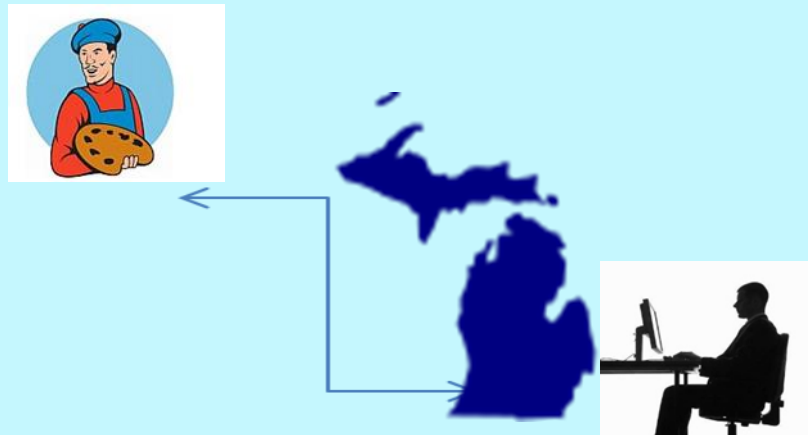
When should the MSA-1656 be completed?

When:

- Standard wheelchairs w/ Custom seating
- Power Wheelchairs
- Power Operated Vehicles (POV's)
- Custom seating
- Or when the beneficiary has a basic functional/medical change

Why does MDHHS need this form?

- Helps the evaluator(s), DME providers & MDHHS staff address **current** basic medical & functional mobility equipment needs



How often must it be completed?

- After the initial, only complete new if medical/functional status changes

i.e.: advancement of disease preventing resident's ability to operate manual wheelchair by himself.

Electronic Version

- Form is available at:
- www.michigan.gov/medicaidproviders < Policy & Forms < Forms
- Fields have unlimited character space.
- Handwritten forms are not accepted. Only handwriting necessary is the Evaluator's signature.

Addendum A

- Clarifies resident's ability to use requested item.
- Complete Addendum A & submit it with the 1656 for:
- Complex seating, a manual wheelchair w/ custom seating, power wheelchairs, scooters, power accessories

Addendum A

- Complete sections that apply to the item(s) being requested
- Send to DME, along with the MSA-1656 (if applicable), MDS, plan of care and nursing notes.
- DME submits above & MSA-1653D to the Program Review Division

Where do I send the MSA-1656?

DME sends documentation to:

MDCH Program Review Division

PO Box 30170

Lansing, MI 48909 or

Fax: (517) 335-0075

For Prior authorization or MSA-1656 questions
1-800-622-0276

MSA-1656 VS. MDS

MSA-1656 Vs. MDS

No DME, not
Within their scope of practice

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES		
Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices		
Completed by physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. Incomplete information will result in the form being returned to the evaluator for completion.		
SECTION 1: BENEFICIARY INFORMATION		
Beneficiary Name: _____	mihealth Number: _____	
Ordering/Referring Physician: _____	NPI: _____	
Physician Specialty: _____		
SECTION 2: MEDICAL HISTORY		
Primary Diagnosis: _____	Secondary Diagnosis: _____	
Onset date: _____	Onset date: _____	
If spinal cord injury or spina bifida indicate the level of injury/impairment: _____		
Relevant past and future surgeries: _____		
Bowel Mgmt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy (Indicate type): _____		
Bladder Mgmt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter (Indicate type): _____		
Cardio Status: <input type="checkbox"/> WFL <input type="checkbox"/> Impaired	Neuro Status: Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Frequency/Duration: _____ / _____	Respiratory Status: <input type="checkbox"/> WFL <input type="checkbox"/> Impaired
Baclofen pump present? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, date Implanted: _____	Sip 'N Puff controller requested? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Botox? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, date of last injection: _____	If YES, additional information may be required: _____	
Other explain: _____		
Height: _____	Weight: _____	Explain recent changes or trends in weight: _____
List medication(s) currently prescribed: _____		
How does the management or severity of the above conditions/impairments affect the need for the equipment requested? _____		

MDS Section I.
Active Diagnoses & Section J.

MDS Section H.
Bladder & Bowel

MDS Sect. N.

MSA-1656 Vs. MDS

SECTION 3: HOME ENVIRONMENT

Beneficiary resides in: ☐ House ☐ Condo/town home ☐ Apartment ☐ Assisted Living /AFC/Group Home ☐ Nursing Facility
Does beneficiary live alone? ☐ YES ☐ NO If NO, does beneficiary have a caregiver? ☐ YES ☐ NO
If YES, who provides the care? ☐ Family member ☐ RN ☐ LPN ☐ Other (explain) _____
How many hours per day are provided by the caregiver? _____

SECTION 4: COMMUNITY ADL (Transportation)

What is the beneficiary's mode of transportation? (Check all that apply.)
☐ Car ☐ Van/SUV ☐ Van w/ Lift ☐ Truck ☐ Taxi Cab ☐ Bus ☐ School bus ☐ Ambulance ☐ Other _____
Does the beneficiary attend school or work? ☐ YES ☐ NO
Is the beneficiary transported in the current or requested wheelchair? ☐ YES ☐ NO If NO, explain why the beneficiary cannot be transported in the current or requested chair?
Explain: _____

MDS Section F.
items R.&S

Preferences outside
facility

SECTION 5: SENSATION AND SKIN ISSUES

MDS Section M. Skin Conditions

Sensation <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Absent <input type="checkbox"/> Hypersensitive	Pressure Relief <input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Type of assistance needed How does the beneficiary perform pressure relief? _____	
Does beneficiary have a history of skin decubiti and/or flap surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, indicate location: _____	Does beneficiary have a current decubiti? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, describe: _____	Does beneficiary have other skin issues? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, describe: _____

MSA-1656 vs. MDS

MDS Sect. G
All of this section

MDS Sect. G
example

A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture
B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)
C. Walk in room - how resident walks between locations in his/her room
D. Walk in corridor - how resident walks in corridor on unit
E. Locomotion on unit - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair
F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair

SECTION 6: MOBILITY ASSESSMENT (Mandatory for all requests)

Functional Ability Without Mobility Device(s)

Sitting:

	Static	Dynamic
WFL	<input type="checkbox"/>	<input type="checkbox"/>
Uses UE for balance	<input type="checkbox"/>	<input type="checkbox"/>
Contact guard assist	<input type="checkbox"/>	<input type="checkbox"/>
Standby assist	<input type="checkbox"/>	<input type="checkbox"/>
Minimum assist	<input type="checkbox"/>	<input type="checkbox"/>
Moderate assist	<input type="checkbox"/>	<input type="checkbox"/>
Maximum assist	<input type="checkbox"/>	<input type="checkbox"/>
Dependent/unable	<input type="checkbox"/>	<input type="checkbox"/>

Standing:

	Static	Dynamic
WFL	<input type="checkbox"/>	<input type="checkbox"/>
Uses UE for balance	<input type="checkbox"/>	<input type="checkbox"/>
Contact guard assist	<input type="checkbox"/>	<input type="checkbox"/>
Standby assist	<input type="checkbox"/>	<input type="checkbox"/>
Minimum assist	<input type="checkbox"/>	<input type="checkbox"/>
Moderate assist	<input type="checkbox"/>	<input type="checkbox"/>
Maximum assist	<input type="checkbox"/>	<input type="checkbox"/>
Dependent/unable	<input type="checkbox"/>	<input type="checkbox"/>

Transfers:

<input type="checkbox"/> Independent	<input type="checkbox"/> Type of assistance needed: _____
How does beneficiary transfer:	
<input type="checkbox"/> Pivot	
<input type="checkbox"/> Sliding	
<input type="checkbox"/> Mechanical Lift	
<input type="checkbox"/> Other: (Explain)	

Ambulation within 1 minute:	<input type="checkbox"/> Independent > or = 150 ft.	<input type="checkbox"/> Unable to ambulate
	<input type="checkbox"/> Ambulates with assist > or = 150 ft.	<input type="checkbox"/> Limited due to endurance - Explain: _____
	Explain type of assistance: _____	
	<input type="checkbox"/> Ambulates with device > or = 150 ft.	
	<input type="checkbox"/> Ambulates short distance only _____ ft.	
Explain how this affects equipment ordered? _____		

MDS Sect. G. Functional Status items B, C, D, E, F

Complete only if power mobility item is requested (e.g., power wheelchair, scooter, power assisted wheels, etc.)

Visual perception: Has visual acuity and perception that permits safe and independent operation of the equipment requested.	<input type="checkbox"/> YES <input type="checkbox"/> NO
Problem solving: Has problem solving skills appropriate to operate requested power mobility item. If beneficiary is unable, who will complete? Explain: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Comprehension: Understands and is able to follow directions and conversations that are spoken or written language. If NO, explain: _____	

Sect. B Hearing/Vision/Speech
Sect. C Cognitive patterns C1000

SECTION 7: MODIFIED ASHWORTH SCALE AND MANUAL MUSCLE EVALUATION INFORMATION

See Form Completion Instructions for Modified Ashworth Scale and Manual Muscle Evaluation.

Width at the:		Height:																												
	Head: _____ Neck: _____ Shoulder: _____ Trunk: _____ Hips: _____ Feet: _____		<table> <tr> <th></th><th>L</th><th>R</th></tr> <tr> <td>Crown:</td><td>_____</td><td>_____</td></tr> <tr> <td>Occiput:</td><td>_____</td><td>_____</td></tr> <tr> <td>Shoulder:</td><td>_____</td><td>_____</td></tr> <tr> <td>Axilla:</td><td>_____</td><td>_____</td></tr> <tr> <td>Elbow:</td><td>_____</td><td>_____</td></tr> <tr> <td>Seat Depth:</td><td>_____</td><td>_____</td></tr> <tr> <td>Leg Length:</td><td>_____</td><td>_____</td></tr> <tr> <td>Foot Length:</td><td>_____</td><td>_____</td></tr> </table>		L	R	Crown:	_____	_____	Occiput:	_____	_____	Shoulder:	_____	_____	Axilla:	_____	_____	Elbow:	_____	_____	Seat Depth:	_____	_____	Leg Length:	_____	_____	Foot Length:	_____	_____
	L	R																												
Crown:	_____	_____																												
Occiput:	_____	_____																												
Shoulder:	_____	_____																												
Axilla:	_____	_____																												
Elbow:	_____	_____																												
Seat Depth:	_____	_____																												
Leg Length:	_____	_____																												
Foot Length:	_____	_____																												

MSA-1656 Vs. MDS

Beneficiary Name: _____ mihealth Number: _____

Head & Neck	<input type="checkbox"/> Maintains upright without support <input type="checkbox"/> Rotated		<input type="checkbox"/> Maintains upright with support <input type="checkbox"/> Laterally Flexed		<input type="checkbox"/> Flexed <input type="checkbox"/> Cervical Hyperextension		<input type="checkbox"/> Extended <input type="checkbox"/> Absent head control	
	ROM (Range of Motion)		MMT/O (Manual Muscle)		TONE		Explain how this affects equipment ordered:	
	<input type="checkbox"/> AROM <input type="checkbox"/> AAROM <input type="checkbox"/> PROM		<input type="checkbox"/> Test <input type="checkbox"/> Observation					
	Left	Right	Left	Right				
Shoulder	<input type="checkbox"/> Flexion <input type="checkbox"/> Abduction <input type="checkbox"/> Internal Rotation <input type="checkbox"/> External Rotation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Flexion <input type="checkbox"/> Abduction <input type="checkbox"/> Internal Rotation <input type="checkbox"/> External Rotation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia			
Elbow	<input type="checkbox"/> Flexion <input type="checkbox"/> Extension <input type="checkbox"/> Pronation <input type="checkbox"/> Supination	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Flexion <input type="checkbox"/> Extension <input type="checkbox"/> Pronation <input type="checkbox"/> Supination	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia			
Wrist	<input type="checkbox"/> Flexion <input type="checkbox"/> Extension	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Flexion <input type="checkbox"/> Extension	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia			
Hand	<input type="checkbox"/> Grip Strength <input type="checkbox"/> Pinch Strength	<input type="checkbox"/> <input type="checkbox"/>						
Knee	<input type="checkbox"/> Flexion <input type="checkbox"/> Extension	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Flexion <input type="checkbox"/> Extension	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia			
Ankle & Foot	<input type="checkbox"/> Dorsiflexion <input type="checkbox"/> Plantarflexion <input type="checkbox"/> Inversion <input type="checkbox"/> Eversion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Dorsiflexion <input type="checkbox"/> Plantarflexion <input type="checkbox"/> Inversion <input type="checkbox"/> Eversion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia <input type="checkbox"/> Clonus: <input type="checkbox"/> Left <input type="checkbox"/> Right			

MDS Sect. G
All

MDS Section O if
Any therapies were
performed

MSA-1656 Vs. MDS

SECTION 8: GOALS

Check all that apply.

- ☐ Independence with mobility in the home and mobility related activities of daily living (MRADLs) in the community (independence is - no help or oversight provided, and has physically demonstrated independence in operating requested equipment)
- ☐ Assisted mobility/occasional assistance with wheelchair propulsion (e.g., verbal cueing, pushing up a ramp or onto a bus, over curbs, etc.)
- ☐ Dependent mobility
- ☐ Optimize pressure relief
- ☐ Proper positioning and/or correction of a physiological condition. Explain:
- ☐ Other: (Explain)

MDS applicable sections & Plan of Care to address

SECTION 9: LIST TYPE OF EQUIPMENT PRESENTLY OWNED OR USED BY THE BENEFICIARY

Brand	Model	Serial Number	Description	Date of Purchase
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

MSA-1656 Vs. MDS

Beneficiary Name: _____ mihealth Number: _____

SECTION 10: MOBILITY ASSESSMENT - FOR BENEFICIARIES IN A NURSING FACILITY ONLY

This section is to be completed by the Nursing Facility Director of Nursing, Nursing Facility Administrator or ordering/referring physician.

Nursing Facility Name: _____	NPI: _____	Date of Admission: _____
Mobility History: <input type="checkbox"/> Uses nursing facility per diem chair <input type="checkbox"/> Uses own personal chair		
Wheelchair Description: _____ (Currently used or owned)	Brand: _____ Model No: _____	Serial No: _____
Components: _____		

Customized Wheelchair Documentation (Required documentation to accompany this form)

☐ Most Recent MDS ☐ Past Two Months of Nursing Notes ☐ Current Plan of Care that relates to the equipment ordered

Director of Nursing Signature

Date

Print Name

Either the physician or the
DON's signature

Ordering Physician Signature

Date

Print Name

MSA-1656 Vs. MDS

SECTION 11: EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information presented in Sections 1 - 9, and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Enter Date Here

Evaluation Date

Enter Text Here

Evaluator Name/Title (Print)

Enter Text Here

Place of Employment and Address

NPI

Phone Number

Evaluator Signature

Date

If the resident also needs custom seating, power wheelchair w/ add-ons or manual wheelchair with custom seating complete Addendum A. If not send the MSA-1656, the MDS, last two months of nursing notes and the Plan of Care to the Durable Medical Equipment provider to send in with the Prior Authorization form.

ADDENDUM A

Addendum A

Complete this form if the resident needs:

- A manual wheelchair with custom seating or
- A power wheelchair and/or
- Custom seating or
- The person needs a replacement of one of the above.

Addendum A

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Addendum A: Mobility/Seating

This form must be completed by a physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. The evaluator must complete requested and/or current equipment, warranty information and economic alternative information.

NOTE: Only complete sections that apply to the requested equipment/accessories.

Incomplete information will result in the form being returned to the evaluator for completion.

Beneficiary Name: <input type="text"/>		Mihealth Number: <input type="text"/>	
--	--	---------------------------------------	--

SECTION(s)	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Manual wheelchair with accessory additions.	<input type="checkbox"/> Propels a wheelchair 60 feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a 3% grade, maneuvers on rugs and over door sills <input type="checkbox"/> Cannot propel manual wheelchair without caregiver assist. <input type="checkbox"/> Cannot propel manual wheelchair, used for transport only. <input type="checkbox"/> Medical reason for power assisted wheels: <input type="text"/>	Specify brand, model and serial numbers, age of current base: <input type="text"/> Chair width <input type="text"/> inches. Chair depth <input type="text"/> inches. Length of warranty: <input type="text"/> Warranty begin date: <input type="text"/> Where will requested device be used? (i.e., home, school, community) <input type="text"/>
	<input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline Medical reasons for function indicated: <input type="text"/> Hours of continuous wheelchair use per day: <input type="checkbox"/> > 4 hours <input type="checkbox"/> < 4 hours; if < 4 hours, how many? <input type="text"/>	

Addendum A

	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Power wheelchair with standard joystick	<input type="checkbox"/> Able to propel manual wheelchair _____ feet. <input type="checkbox"/> YES <input type="checkbox"/> NO Beneficiary is able to drive a power wheelchair independently _____ feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a minimum of a 3% grade, maneuvers on rugs and over door sills. If NO, explain: _____ Chair width _____ inches. Chair depth _____ inches.	Specify brand, model and serial numbers, age of current base: _____ Chair width _____ inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? (i.e., home, school, community) _____
	Power functions requested: (Check all that apply.) <input type="checkbox"/> Recline <input type="checkbox"/> Elevating seat <input type="checkbox"/> Center mount elevating leg rests <input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline <input type="checkbox"/> Elevating leg rests <input type="checkbox"/> YES <input type="checkbox"/> NO Able to perform, manipulate or work all seat functions without assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO Requires verbal and/or physical assistance to manipulate seat functions? <input type="checkbox"/> YES <input type="checkbox"/> NO Has pressure relief plan of care with equipment? If YES, (explain) _____ Hours of continuous wheelchair use per day: <input type="checkbox"/> > 4 hours <input type="checkbox"/> < 4 hours; if < 4 hours, how many? _____	Manual functions requested: <input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline

Addendum A

	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Equipment	Beneficiary's ability to use	
Power wheelchair with alternate controls	<p> <input type="checkbox"/> Able to propel manual wheelchair _____ feet. <input type="checkbox"/> YES <input type="checkbox"/> NO Beneficiary is able to drive a power wheelchair independently _____ feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a minimum of a 3% grade, maneuvers on rugs and over door sills. If NO, please explain: _____ Chair width _____ inches. Chair depth _____ inches. </p> <p> Specify brand, model and serial numbers, age of current base: _____ Chair width _____ inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? (i.e., home, school, community) _____ </p> <p> Power functions requested: (Check all that apply.) <input type="checkbox"/> Recline <input type="checkbox"/> Elevating seat <input type="checkbox"/> Center mount elevating leg rests <input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline <input type="checkbox"/> Elevating leg rests </p> <p> Manual functions requested: <input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline </p> <p> <input type="checkbox"/> YES <input type="checkbox"/> NO Able to perform, manipulate or work all seat functions without assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO Requires verbal and/or physical assistance to manipulate seat functions? <input type="checkbox"/> YES <input type="checkbox"/> NO Has pressure relief plan of care with equipment? Explain: _____ Specify control needed: _____ </p> <p> Medical need for control indicated: _____ </p> <p> Indicate the beneficiary's ability to use in their environment: _____ </p> <p> Hours of continuous wheelchair use per day: <input type="checkbox"/> > 4 hours <input type="checkbox"/> < 4 hours; if < 4 hours, how many? _____ </p>	

Make sure to fill out all areas.

Addendum A

	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Power wheelchair standing feature	<input type="checkbox"/> Beneficiary has a history of pressure ulcers on pelvis, buttocks, hips or back <input type="checkbox"/> Will be used for pressure relief in lieu of tilt, recline, tilt/recline, and custom seating <input type="checkbox"/> Pressure relief is done by the beneficiary without assistance If assistance with pressure relief is required, indicate amount and frequency needed: _____ Chair width _____ inches. Chair depth _____ inches. Indicate current pressure relief plan of care (including frequency and duration): _____ Is beneficiary/caregiver compliant with current pressure relief plan of care? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, explain: _____	Specify brand, model and serial numbers, age of current base: _____ Chair width _____ inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? (i.e., home, school, community) _____

Addendum A

Equipment	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Scooter	<input type="checkbox"/> Able to propel manual wheelchair _____ feet. <input type="checkbox"/> Independent trunk balance, <input type="checkbox"/> Adequate bilateral hand functions to work tiller. Chair width _____ inches. Chair depth _____ inches.	Specify brand, model and serial numbers, age of current base: _____ Chair width _____ inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? (i.e., home, school, community) _____

The on-line version has unlimited text space in the boxes

	Device Type (attach additional page(s) if necessary)	
All Accessories / Add Ons	<input type="checkbox"/> Head & Neck _____ <input type="checkbox"/> Arms _____	<input type="checkbox"/> Feet <input type="checkbox"/> Footbox _____ <input type="checkbox"/> Other - Describe _____
Medical Reason	List and specify Medical Reason for brand(s) and model(s) requested for this beneficiary: _____ The medical reason must be provided for all accessories and add-ons	

Growth adaptability of device	Requested	Current
REQUIRED	Seat width: (inches) _____	Seat width: (inches) _____
	Back height: (inches) _____	Back height: (inches) _____
	Seat depth: (inches) _____	Seat depth: (inches) _____
	Maximum frame growth: (inches) _____	Maximum frame growth: (inches) _____

Addendum A

Custom Seating




SEATING SYSTEM

Medical/functional Reason

- ☐ New growth > 3 inches depth and/or > 2 inches width
- ☐ Change in width and depth; width inches depth in inches
- ☐ Orthopedic change; explain:
- ☐ Needs corrective forces to assist with maintaining or improving posture.
- ☐ Accommodate beneficiary's posture (e.g., current seating postures are not flexible, etc.).
- ☐ Other medical changes that affect the need for new positioning; specify:






POSTURE:

COMMENTS:

	Lateral View	AP View	Superior View	
TRUNK	<p>Anterior / Posterior</p>  <p><input type="checkbox"/> WFL <input type="checkbox"/> ↑ Thoracic <input type="checkbox"/> ↑ Lumbar</p> <p>Kyphosis Lordosis</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Flexible</p> <p><input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other</p>	<p>Left Right</p>  <p><input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right</p> <p><input type="checkbox"/> c-curve <input type="checkbox"/> s-curve <input type="checkbox"/> multiple</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Flexible</p> <p><input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other</p>	<p>Rotation-shoulders and upper trunk</p>  <p><input type="checkbox"/> Neutral</p> <p><input type="checkbox"/> Left anterior</p> <p><input type="checkbox"/> Right anterior</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Flexible</p> <p><input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other</p>	<p><input type="checkbox"/> Hypertonia</p> <p><input type="checkbox"/> Hypotonia</p> <p><input type="text"/></p>

Addendum A

Custom Seating

	Anterior View	Superior View	ROM	MMT/O
HIPS	<p>Position</p>  <p> <input type="checkbox"/> Neutral <input type="checkbox"/> Fixed <input type="checkbox"/> Subluxed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Dislocated <input type="checkbox"/> Flexible </p>	<p>Windswept</p>  <p> <input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other </p>	<p>Hip Flexion/Extension Limitations: (PROM in Degrees)</p> <input type="text"/>	<p>Hip Internal/External Range of Motion Limitations:</p> <input type="text"/>
PELVIS	<p>Lateral View</p> <p>Anterior / Posterior</p>  <p> <input type="checkbox"/> Neutral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other </p>	<p>AP View</p> <p>Obliquity</p>  <p> <input type="checkbox"/> WFL <input type="checkbox"/> R elev <input type="checkbox"/> L elev <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other </p>	<p>Superior View</p> <p>Rotation-Pelvis</p>  <p> <input type="checkbox"/> WFL <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Fixed <input type="checkbox"/> Anterior <input type="checkbox"/> Anterior <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible <input type="checkbox"/> Other </p>	<p>If spinal curvature present, indicate degree.</p> <input type="text"/>

Addendum A

Requested Seating System		Current Seating System <input type="checkbox"/> None	
Length of warranty? <input type="text"/>		Length of warranty: <input type="text"/>	
Mobility device to be used with: <input type="text"/>		Warranty begin date: <input type="text"/> Mobility device is used with: <input type="text"/>	
<input type="checkbox"/> Planar/Non-custom contour	<input type="checkbox"/> Custom *	<input type="checkbox"/> Planar/Non-custom contour	<input type="checkbox"/> Custom *
Manufacturer: <input type="text"/>	Type: <input type="text"/>	Manufacturer: <input type="text"/>	Type: <input type="text"/>
Components include: <input type="checkbox"/> Seat only <input type="checkbox"/> Back only <input type="checkbox"/> Back and Seat	Components include: <input type="checkbox"/> Seat only <input type="checkbox"/> Back only <input type="checkbox"/> Back and Seat	Date provided: <input type="text"/> Components include: <input type="checkbox"/> Seat only <input type="checkbox"/> Back only <input type="checkbox"/> Back and Seat	Date provided: <input type="text"/> Components include: <input type="checkbox"/> Seat only <input type="checkbox"/> Back only <input type="checkbox"/> Back and Seat
Lateral Components Include: <input type="checkbox"/> Trunk <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Abductor <input type="checkbox"/> Anti-thrust	Lateral Components Include: <input type="checkbox"/> Trunk <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Abductor <input type="checkbox"/> Anti-thrust	Lateral Components Include: <input type="checkbox"/> Trunk <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Abductor <input type="checkbox"/> Anti-thrust	Lateral Components Include: <input type="checkbox"/> Trunk <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Abductor <input type="checkbox"/> Anti-thrust
Other Components - List: <input type="text"/>	Other Components - List: <input type="text"/>	Additional Components: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe: <input type="text"/>	Additional Components: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe: <input type="text"/>
<p>If requesting custom seating, specify why planar/non-custom contour does not meet beneficiary's medical needs. <input type="text"/></p> <p style="color: red; text-align: center;">This must be filled out.</p>			
<p>* For definition of custom refer to MDHHS Medicaid Provider Manual, Medical Supplier Chapter, sections Standard Equipment and Custom-Fabricated Seating, and section Standards of Coverage</p>			

Addendum A

EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information in the appropriate Sections of the MSA-1656-Addendum A and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Evaluation Date

Evaluator Name/Title (Print)

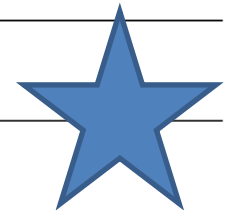
Place of Employment and Address

NPI

Phone Number

Evaluator Signature

Date



If the MSA-1656 was completed, send it & the entire MDS, last two months of Nursing notes, the most recent plan of care to the DME. The DME will send all with the Prior Authorization request. If the MSA-1656 was not needed (i.e. no significant Medical/functional changes in the resident's status, just needs a replacement, only Send Addendum A, the entire MDS, last two months of nursing notes, most recent plan of care to the DME provider to send in with the prior authorization request.



QUESTIONS???